

DOCUMENT RESUME

ED 151 715

CG 012 378

AUTHOR Lesnoff-Caravaglia, Gari
TITLE US/USSR Educational Intervention.
SPONS AGENCY Fogarty International Center (DHEW/PHS), Bethesda,
Md.
PUB DATE [77]
NOTE 20p.
EDRS PRICE MF-\$0.83 HC-\$1.67 Plus Postage.
DESCRIPTORS *Comparative Education; Cross Cultural Studies;
*Geriatrics; Gerontology; *Health Personnel; Health
Programs; Intervention; *Medical Education;
Preventive Medicine; Program Evaluation; Senior
Citizens
IDENTIFIERS *USSR

ABSTRACT

Based on the researcher's observations during a month-long visit to the Soviet Union as a specialist in gerontology and guest of the Soviet Ministry of Health, comparisons were drawn between educational intervention procedures in gerontology and/or geriatrics for health care professionals in the Soviet Union and the United States. Locus of such intervention, program content, length of training, and personnel involved were recorded at a total of nine Gerontology/Geriatric Centers and Institutes in Leningrad, Kiev, Moscow, and Tbilisi. Programs of nine institutions in the United States providing such professional educational intervention for health care professionals were contrasted with the educational intervention programs in the Soviet Union. The results of such comparison indicated that neither nation is preparing or retraining sufficient numbers of health care personnel to deal adequately with the increasing numbers of older persons within their populations. The Soviet Union surpassed the United States only in the development of particular research areas. (Author)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

ED151715

US/USSR EDUCATIONAL INTERVENTION*

Gari Lesnoff-Caravaglia, Ph.D.

Associate Professor, Gerontology
Director, Gerontology Program
Sangamon State University
Springfield, Illinois 62708

(217) 786-6590

* Research sponsored by the Fogarty International Center under the
US/USSR Agreement for Technical and Scientific Cooperation.

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS
MATERIAL HAS BEEN GRANTED BY

G. Lesnoff-Caravaglia

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC) AND
USERS OF THE ERIC SYSTEM."

CG 012378

Educational intervention in gerontology/geriatrics in the United States and the Soviet Union can best be appreciated by viewing such intervention against the broader background of general provisions of health care in both countries.

In the Soviet Union, preventive medicine is the primary focus of medical practice and medical education. Every medical effort is directed towards this goal for all age groups, including the elderly. Medical assistance is readily available as the entire nation is divided into medical regions with one physician serving approximately 345 persons, regardless of age, in each region. In such regional divisions are also located medical teams made up of nurses, physicians, and medical social workers, and an additional core of specialists as consultants. The emergency service is efficient organized and often employs the services of a paramedical in the person of the feldsher. Such promotion of health measures, along with improvement in sanitation, are national priorities. Physical education and sporting activities are prominent features of the health program and are encouraged at all age levels---including old age.

The Soviet health system recognizes its dependence upon scientific progress in medicine. Medical research has as its principal goal the preservation of health and the extension of human active life. The shortage of human resources for the developing economy in the Soviet Union has encouraged scientific research and the training of research personnel, as well as skilled health specialists in these areas. These interests also have profound social and economic implications.

The Soviet Union has developed a broad network of preventive and curative medical services which cover the entire nation. The scope of the health services provided to the general population is broad, but because of the country's low standard of living, Soviet public health is inferior qualitatively to many Western countries. The result of such organization, however, is that older persons can remain within their own communities, prolong their work life, are assured support services for optimal functioning and independence.

Medical aid is public and free of charge. Older persons enjoy the privilege of both in-patient and out-patient medical care, as well as a doctor's home visiting service which is regarded within the health system as essential to proper geriatric care. Patients with cardiovascular and gastrointestinal diseases are followed up at special health centers and dispensaries. Although geriatrics is regarded as a separate field, it is not a medical specialty.

Therapists (internists) lead the way in treatment of patients over 60. They receive more than half of all patients coming to the clinic, and they have the majority of house calls to attend to. There has been some concern evidenced in regard to improving the qualifications and narrow specialization of the therapists working in the field of gerontology/geriatrics.

Older persons are divided by age into three categories: Those between 60-75 are referred to as mature (zrosli); 75-90, old (starii); and, 90+ as long-living (dolgozichili). To create normal conditions of life for dependent older persons, special nursing homes and Homes for the Aged have been developed in the Soviet Union. Such institutions are state supported. There are approximately more than 1000 homes for invalids and older persons. More than 200,000 older persons reside in such institutions, or about one-

half of 1% of the elderly population. Many collective farms have their own Homes for the Aged. Specially trained doctors and nurses take medical care of the people in such homes, and large homes have clinical-diagnostic laboratories and laboratories for physical therapy.

Much attention is paid to the problem of proper rest and recreation for pensioners and veteran workers. A number of sanatoria and rest homes are found throughout the nation which operate totally at the state's expense.

The planning of medical education is done at the national level, as is the assignment of newly graduated medical staff, the training of scientific workers and advanced training of medical personnel. There are uniform technological policies and specifications in the medical industry, uniform national and interindustry standards for new medical projects. Public health planning is an inseparable component of national economic planning.

As a result, demography is an important aspect of health care, and is an important unit in every department of government. Since health planning involves the total nation, budgeting, allocation of personnel, distribution of services, etc. all must be strictly carried out according to needs and numbers. Who the elderly are, in what numbers, where they live, what are the health conditions, are vital to such planning.

The organization of health care for the elderly is developed as a component within the general system of therapeutic and prophylactic health services serving the total population, and thus special mention of geriatric needs do not frequently appear. There is great emphasis placed upon the accessibility of such services to all older persons since the elderly constitute an increasingly large portion of the Soviet population and figure prominently in the work force. Such concern has fostered the development of a network of dispensary-polyclinics and home visiting services.

The goals of such therapeutic measure include not only the curing of pathological processes, but the providing of psychological and emotional support as well. The responsibility of medical care is seen as encompassing areas such as positive motivation, maintaining or increasing the activity level, and the encouraging of independence.

Planning with respect to the form that health care services for older persons should take, incorporates not only the problems of organization and the amount of care required, but takes into consideration the structure of the aged population, environmental aspects, as well as the current state of health of this population, and so on. The prevention and lowering of morbidity, the eradication of mass-scale infectious diseases, etc. are all directed toward the increasing of human life expectancy.

One of the main tasks involved in improving the quality of health care for older persons is the increasing number and scope of the system of advanced training of physicians (which lasts as long as three months in some instances), primarily internists, in gerontology and geriatrics.

In the Soviet Union, the special chair of gerontology and geriatrics was founded at the Kiev Gerontology Institute. In the Center for Advanced Training of Physicians of the Institute emphasis is placed upon the improvement of qualifications of physicians working in residential homes, geriatric clinics and other therapeutic and prophylactic institutions which serve older persons.

There has been a steady growth in the Soviet Union of the numbers of aged patients. Persons aged 60 and above, now form 11.8% of the population. Of this number 18% visit a physician annually. There is an obvious need to develop greater geriatric expertise in the dispensary-polyclinic divisions of medical institutions.

One of the weakest areas in the continued development and maintenance of the Soviet public health network is the availability and training of medical personnel. In spite of the steps already taken to broaden personnel training and to shorten the training time at higher and secondary medical educational establishments, there is still some difficulty experienced in manning the entire network, particularly in industrial regions and rural areas. Physicians holding more than one position is still a feature in today's medical practice.

The retaining of older persons in the work force and the maintaining of the general well-being of older individuals, is closely related to Soviet expenditures on public health and social welfare. A further consideration is the factor of time expenditure---the loss of work hours by family members as caretakers of the elderly, as well as time spent by nurses in caring for the ill and incapacitated elderly. Not only is the severe manpower shortage experienced in the work force in general, but in the health care fields, as well. It is within the social and economic interest to keep older persons healthy and productive as long as possible.

Concern for proper health care which causes great anxiety among older Americans is largely absent in the Soviet Union. Most elderly persons are cared for by their families, except in some of the highly industrialized regions of the Soviet Union where institutionalizations is becoming more commonplace. The fear of living alone is also partially mitigated by the "Skoraya Pomoshch" system. This is the famed emergency medical service system of the Soviet cities by which the health care establishment responds to calls of distress from its citizens.

A citizen dials 03 on any phone which connects him/her immediately with the operators of a central dispatching office. A crew of switchboard operators handle the incoming calls, passing those calls requesting judgmental decision to the two physicians on duty. The physicians determine disposition of the problem, write the order, and the dispatching switchboard crew makes disposition---either by phone to its own ambulance station at the Center, or to one of 22 substations (in Moscow) or by radio-phone to an ambulance already known to be in the area.

Each of these ambulances is manned by a medical staff and always includes a doctor, a driver, and at least one specially trained feldsher. The ambulances are specialized into coronary-care units, shock units, stroke units, and children's care ambulances. They are equipped and staffed accordingly.

While over 90% of all feldshers in the Soviet Union are women, only 60% of the Skoraya feldshers are because of the demands of their particular kind of work. Work on the Skorya service includes dealing with the traumatized, the unconscious, and sometimes the inebriated. Many young physicians and feldshers operate the Skoraya Pomoshch and exhibit great zeal and enthusiasm for this work. They are often spoken of as exemplifying the kind of team work expected in prompt and adequate medical care.

Work on Skorya Pomoshch demonstrates an important aspect of Soviet medical education. It is highly differentiated and goal-oriented. Such an orientation is found in the medical institutions as well as in the training institutions for the feldshers and nurses as well. There is some suggestion of such specification even in the general 10-year school which nearly everyone attends. Such an orientation must be understood, again, in terms of the over-arching state goals and aspirations which are largely utilitarian.

The USSR has needed qualified workers in the medical field---and it is in just this way that physicians are regarded---in large numbers and within a very short span of time. The training of physicians continues at a very rapid rate, and, at what appears in some instances, at the expense of developing a more intellectually disciplined profession. The emphasis is more upon the acquisition of skills and immediately applicable knowledge in order to function adequately as part of a highly organized and supervised health care system.

Because of the early process of differentiation and specialization, each group of health care personnel is educated in specific institutions. Physicians, for example, are educated in medical institutes, for which a 10-year general education background is required. The instruction is highly regimented and is the same in all medical institutes throughout the Soviet Union. Medical students are required to pass State examinations.

All workers in the field of medicine---whether feldshers or nurses---share a common responsibility to the state and therefore to society, and neither is regarded as an independent health care profession. The profession is medicine---and all components of the system, whether teaching, direct care or administration---comes under the same heading and are run directly by the doctors.

It is difficult to draw educational parallels in medical training between the nations for there is no exact academic equivalent in the United States to either Soviet degree---"doctor of medical science" and "candidate of medical science."

Medical education requires six years and as postgraduate training, physicians undergo subsequent specialization of usually one year's duration. The quantity of physicians graduated each year is impressive, but the quality of their education and the use to which they are sometimes put, has made them little more than technicians.

Upon graduation from the Medical Institute, the student is awarded the degree of "Candidate of Medical Science." This degree is not normally equated with the American Doctor of Philosophy degree because the course of studies undertaken is normally much narrower in scope than that taken by the American Ph.D. candidate. The graduates are known, however, as "doctors." The "Doctor of Science" degree is awarded to a selected number of investigators who have received a Candidate of Medical Science degree and have performed distinguished research for a number of years on a difficult problem.

The candidate group is made up primarily of women who work a 40-hour week in very specific jobs and often maintain the role of wife and mother in the home. Those who advance beyond this point are usually men with research interests that lead them to receiving the doctorate and, when appropriate, the title of professor.

Also, there is the added difference in that the Soviet physician spends less time in school than does his American counterpart. After the 10-year general education experience, the Soviet student spends seven years at the medical institute. The Soviet "specialty" year after graduation resembles more an American internship. Following the completion of the Institute, the student becomes a general physician caring for adults, a pediatrician or an obstetrician.

The American physician, on the other hand, spends some 12 years in educational programs beyond the high school level. The average training period for the American doctor upon completion of the internship is an additional three years. Thus, the physician of the generalist type still spends four years longer being trained than does the Soviet physician.

There is an additional difference in that in the United States specialization is regarded as an individual accomplishment which is the result of long and persistent personal effort. Specialization, in the Soviet Union, is more the result of assignment because of vacancies or general national health needs. Many physicians working in Gerontology Institutes arrive there through such assignment.

In the United States over 80% of the Medical School graduates take to five years of postgraduate specialized training—almost none of this is devoted to geriatrics or even a cursory overview of the aging field. Such negligible training is also true for nurses, with few exceptions, and most nurses currently employed in long-term care facilities and other health establishments serving older persons have developed their capabilities in the practical school of experience—that is, on the job.

There are a number of reasons why the treatment of older persons in the United States is unpopular and regarded as unnecessary. The principle factor is attitude. Ageism operates in the medical field as well as in the larger society. This is not surprising, since health care personnel, brought up in such a cultural milieu do not bring special perspectives to their chosen field, nor are these attitudes counteracted by education or training. General negative attitudes reinforce the indifference toward the aged and results in the lack of educational training and provision of services.

Furthermore, older persons have not been very visible in society. They are either hidden away in their own homes, in institutions, or in segregated communities. The older persons medical students are apt to see, and this only in a few medical schools across the nation, are ill and probably have been suffering from a variety of ailments all of their lives. The healthy aged are not seen by physicians—and are only begun to be seen by the larger public as well. The myths and stereotypes which currently abound may in the future be dispelled by the ever increasing numbers of older persons in society who will insist upon equity of treatment.

The present negative view of the processes of aging and the aged, has also prevented medical personnel in the United States from regarding the older persons' ailments as treatable. There is not the search for causes in the illnesses experienced by the elderly, and unfortunately, in this day and age, there are still notations on death certificates giving the cause of death as "old age."

Autopsies are not performed at the same rate as they are in the case of young persons, nor are accidental deaths carefully investigated. The whole emerging issue of the abuse of the elderly may begin to deal with the unexplained falls, fractures, concussions, burns, etc. which appear on death certificates as having occurred in the home environment, as well as in the institutional settings.

This in sharp contrast to the experiencing of aging in the Soviet Union. The elderly person is encouraged to keep on working, either at his former post, or by transferring to one that provides lighter work and less time commitment. The family role does not change significantly, but perhaps is intensified because of the real need of the grandparent to help with the families of children. The older woman is endearingly termed "babushka" and cares for the next generation. The healthy aged are everywhere

in evidence, and those who fall ill, remain visible as they are nursed within the family until death.

The positive attitude toward older persons in the Soviet Union can also, in part, be attributed to the fact that the persons who are now among the aged were those who had suffered the most during the great Patriotic War (World War II). A great deal of attention, special consideration, and a variety of benefits are granted anyone who has experienced loss in the War—either through personal physical loss, the loss of loved ones in terms of family, and the loss of continued work opportunities to provide for old age. There is much attention paid to handicapped persons of all ages in the Soviet Union. Those elderly who, because of loss of family who might have cared for them in their old age, are forced to live in homes for the aged are regarded as war victims and are accorded special dignity and privileges because of such loss. They have been bereft of family because sons, husbands, and daughters had died fighting the enemy in the Great Patriotic War. Also, there is commiseration with the elderly, for it is this group that had had the misfortune to live so long under the misguided rule of the Czar. It was also the elderly who had had the wisdom to develop the Soviet Union as a modern industrialized nation from a backward, rural and agricultural fiefdom of the Czar.

As the praises of the heroic dead are sung throughout the nation with monuments to those who died in battle a prominent landmark in every city, so are the praises pronounced of those who had endured hardship and suffering in their youth in order to promote the growth and welfare of the Soviet Union and lost their loved ones in the process. Those who had thus suffered must be revered and cared for in times of illness and distress, through whatever trials are imposed upon them because of their handicaps, and eventually during the last days of their lives.

As part of the history they learn, children learn to identify their obligations as citizens as being directed toward the elderly. The flowers they are schooled to bring to the hospitals, the visits they make to the elderly living alone, and the organized helping groups developed through youth organizations such as the Pioneers, all serve to promote the well being of the deserving elderly, and also introduce the children of increasingly small families (nuclear family structure) to members of other generations.

The institution of the Babushka...the grandmother who in reality raises the children...usually of her daughter...introduces the older person in a positive role within the family and within society. She, also, is allotted her own room in the apartment, which means a larger apartment for the entire family, and has her own retirement income. Economically it is wiser to include an older person within the household, for above personal benefits, there are the support services in the community to help once the older person becomes disabled or ill.

The training of the physician treating older persons in the Soviet Union may not be directly in a specialty called geriatrics...but such knowledge is interspersed in his training and in his clinical experience. Once in practice, he/she finds confronting the older patient as part of his normal patient load an everyday experience. There is further the opportunity available to study at the Advanced Study Centers or at the Gerontology Centers and Institutes for the development of greater expertise and knowledge in geriatrics.

In the United States the basic professional curricula of the core professions providing medical care to aging patients (family practice, internal medicine, psychiatry, and nursing) contain little or nothing specific to working effectively with the specialized aspects of care of the aging. The often aired arguments as to whether geriatrics is a specialty or not in the face of

a greatly increased requirement for medical services are as practically based as medieval discussions of how many witches can dance on the point of a needle.

The emphasis in American medical training has been on the treating of acute illnesses, rapid cure and release of the patient to the home and his assumption of an independent existence. The treatment of older persons is in diametric opposition to such a pattern. The older person is usually suffering from a chronic ailment—one or more—will have a prolonged hospital stay with little or no dramatic change in condition with possibly a gradual decline or even death. Even should there be some improvement in the patient's condition, it is very likely that the discharge is to an intermediate care center, a nursing home, or greater dependence upon existing family. Such a change in the nature of medical practice is insufficiently recognized in the United States.

In part, the lack of provision of medical care for older persons hinges on what appears to be a tug of war between the integrationists and separatists. Medical schools appear to be divided on two main issues: (1) the need for a separate department of geriatric medicine in medical schools. The argument being that the elderly have specific medical problems requiring special attention, and (2) there is no need to single out the treatment of the elderly in our medical schools because aging is a developmental phenomenon and there are no diseases that strike the elderly alone. Instructions about the medical problems of the elderly can be integrated into conventional course work.

In American medical schools, geriatrics appears in the form of electives with some 45 schools now offering such experiences. Other schools include geriatric medical exposure in nursing homes during the family practice residency and possibly during the internal medicine residency. In general, geriatric medicine has not received the kind of stature in the United States that would attract physicians in training to work in this area.

It appears that gerontological/geriatric education in the United States is still in the wishful stage---with much dialogue occurring with respect to what ought to be done---and from the vantage point of aspirations, rather than accomplishments. This was true of the majority of the nine schools contacted for this study.

In the Soviet Union excellence in geriatric medicine, like any other clinical discipline is recognized as having to rest on a solid scientific foundation. It is regarded as essential that training programs in geriatric medicine include fundamental research in the problems of the aged as well as in the process of aging.

As a general observation one could state that although both nations---the US and the USSR---face an increase in their aging population, the emphasis in dealing with these problems differ considerably. In the Soviet Union the priority in aging is to find new knowledge with particular interest in new ways of preventing, modifying and even reversing some of the deleterious aspects of the aging process. There are constant references in the Soviet literature to "premature" aging. Such a search for new knowledge means fundamental understanding through research.

In the United States there is not such a national focus on research in aging, nor have the problems of aging been regarded in such a systematic fashion.

Part of the differences between the approaches of the two nations may lie in the fact that there is a severe manpower shortage in the Soviet Union and the older (veteran) worker is as much needed as is the worker at any other age level. Preventive health is directly related to maintaining a full and active work force. Since much of the work force is made up of women, there is much effort expended in proper care for women in times of pregnancy and child birth and care for children in order to free the woman to participate in the work force. The health of women, in particular, is viewed from a lifespan perspective.

In both nations there is a need for geriatric consultants thoroughly versed in the diseases of aging patients and the age-related changes which occur in the absence of disease. Soviet research, however, has focused on the long-living peoples in order to determine their ability to live to advanced old age while experiencing various forms of pathology. In both countries, however, there is need for clinical and research information concerning the age-related changes in disease and normal old age. This is particularly of interest in the Soviet Union in light of their efforts to promote and activate modern preventive and therapeutic measures in order to keep the elderly healthy and to improve their health when disease intervenes.

#

"U.S./U.S.S.R. Educational Intervention"
Gari Lesnoff-Caravaglia, Ph.D.
Sangamon State University
Springfield, Illinois 62708

CONDITION OF THE AGED

U.S.

High rate of dependence
Undiagnosed and untreated diseases
Unproductive
Fearful of crime
Dissatisfied with themselves

Isolated, institutionalized
Restricted sex life
Suicide

Future Challenge

Extend fruitful middle years
(healthy and vigorous years)

Productive members of society

In order to meet the challenge:

Intensify our attempts to improve
the economic and social conditions
under which older people live now
and will live in the future

Alter negative attitudes toward
the aged (ageism)

U.S.S.R.

Greater independence
National system of health care
Continued work opportunities
Crime negligible
Seen as part of the larger community
(the state); pride in achievement

Live with families
Long living - active sex life
Almost non-existent
(low national rate)

Same—but have already laid the
foundation

Improvements for total society -
improvements for the elderly are
developed within this larger frame-
work - the low standard of living
is shared by all as well

No negative stereotyping - decline
recognized, but is regarded in total
context of human developmental cycle

Healthy aged much in evidence - continue
to work

Family roles continue - "babushka" a
national institution

Condition of the Aged (cont'd)

U.S.

In order to meet the challenge: (cont'd)

Can acquire new knowledge about the aging process and the diseases associated with aging

Physicians receive little or no training in geriatrics

Research

Hope to convince public of the importance of research

Impatience with research that does not give evidence of immediate applicability or quick results

U.S.S.R.

Main thrust of Soviet study of aging is to determine what is normal aging --- what are the diseases of old age and how can they be controlled and treated

Accepting social climate - fewer psycho-bio-medical problems

Research - biomedical

Death of long living - wearing out, no real history of pathology

Active search for new knowledge - new ways of preventing, modifying, and even reversing some of the deleterious aspects of the aging process

Informal inclusion of geriatric training in curriculum; continuing medical education at the Advanced Training Centers for Physicians and at Gerontology Centers and Institutes

Geriatrics - team approach

Research regarded as the ultimate service and the ultimate cost container
Longitudinal studies -- basic research in biochemistry and cell biology
Establishment of physiological norms in the elderly

Laborious experimenting and publishing -- frequent research conferences - support of research by the national government

Doctoral degree - MD - beyond Candidate in Medicine - dependent upon research

Research Institutes ubiquitous - some criticism of the number - highly specialized

Applied and Clinical Research

Condition of the Aged (cont'd)

U.S.

U.S.S.R.

Research (cont'd)

Adjustment to life crises -
psycho-social gerontology

Little research in this area

Rapid transfer of fruits of
research from bench to
bedside

Many prolonged periods of waiting
and replication must be expected

Uneven evaluation

Must be properly tested and evaluated

Need unit of government to
evaluate new scientific
discoveries before physi-
cians are permitted use

* Research sponsored by the Fogarty International Center under the
US/USSR Agreement for Technical and Scientific Cooperation.